The clinic's court petition alleges that the health network provides an incentive for doctors to deny care and reject sick patients, which would be a violation of state law.

''I don't think that you would want your doctor to think about whether it would cost him money personally if he prescribes medicine that you need,'' said David Humphrey, the clinic's administrator. ''We think it's wrong, and we've been advised that it's illegal.''

Under Harris' contracts with its physicians, the company pays doctors a set monthly fee to provide all necessary care to each Harris HMO patient. That fee, which is a percentage of each member's premium, ranges from $11.87 to $15.19 per month.

In addition, doctors are entitled to spend 9.6 percent of each premium dollar on prescriptions. If they exceed that budget, the contract requires them to pay Harris 35 percent of the additional cost. If they spend less than the budget allowed, they receive a bonus.

Harris has awarded $338,000 in bonuses during the last quarter, Dr. Cavazos said. He didn't disclose the amount of fines assessed to doctors.

According to a confidential memo obtained by The Dallas Morning News, Harris doctors exceeded their pharmacy budget by more than 26 percent last year. Internists, who generally treat sicker patient, surpassed their budget by 46 percent, the memo says.

''I've been amazed at the number of people who have been suffering and paying this in silence,'' said Robin Weinman, executive director of the Tarrant County Medical Society. ''I don't know how they're surviving, quite frankly.''

Internist Karen Spetman said she was billed $10,000 by Harris in July for exceeding her pharmacy budget during the first six months of the year. That accounts for about 15 percent of the fees she has received from Harris, she said.

''Nobody works for free,'' she said. ''But right now, that is what I'm doing. I'm not even working for free—I'm working for a negative number. I am paying money for the privilege of practicing medicine.''

Dr. Spetman, the only Harris internist in the Fort Worth suburb of Willow Park, said she has met repeatedly with Harris representatives to explain her problems. When she reviewed her patient charts and prescriptions with a Harris pharmacy director, she was told that she was making the correct medical decisions, she said.

Harris officials did not contest Dr. Spetman's claims. But they said doctors in the system need to realize that increased efficiency and short-term sacrifices will eventually lead to long-term savings.

''When you get a bill, you're hopping mad,'' said Harris spokeswoman Lisa O'Steen. ''But if you look at it in the long term, because Harris has such a high retention of patients and doctors, this is a savings you see over a long period of time.''

TRIBUTE TO SPECIAL AGENT VITO S. DeMARCO

HON. ROSA L. DeLAURO

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 4, 1997

Ms. DELAURO. Mr. Speaker, I rise today to recognize Special Agent Vito S. DeMarco of the U.S. Treasury Department, Bureau of Alcohol, Tobacco and Firearms, on the occasion of his retirement. After 30 years of diligent service in law enforcement, Special Agent DeMarco has built a distinguished reputation of protecting the United States and her citizens.

Special Agent DeMarco began his career with the Office of Naval Intelligence in 1967, after graduating from Fairfield University in Fairfield, CT. After his assignment to the Naval Investigative Service in New York City, Special Agent DeMarco spent the last 28 years of his tenure with the Boston Field Division of the Bureau of Alcohol, Tobacco, and Firearms.

During his tenure with BATF, Special Agent DeMarco distinguished himself by serving on several task forces, including the Sky Marshall Program during the 1970's. He has made his expertise available to the U.S. Secret Service, serving on protection details during the Presidential campaigns of Presidents Ford, Carter, Bush, and Clinton. In addition, he has contributed to the protection details of several foreign heads of state and conducted investigations into illicit firearms trafficking and numerous explosives and arson cases.

Special Agent DeMarco also served with distinction in the U.S. Navy Reserves, from which he retired in 1996 with the rank of commander. His 33 years of naval service included his activation for the Persian Gulf War, in which he commanded a special security division.

Special Agent DeMarco also demonstrated his steadfast commitment to his country and community by volunteering to work with the Marine Cadets of America. Mr. DeMarco has given a great deal of his time and energy to this organization, and has served on the board of its national office.

Law enforcement personnel serve our country by putting their lives on the line, ensuring the safety of our citizens. We owe them all a great debt of gratitude, so it is with the deepest appreciation and pride that I salute Special Agent DeMarco today.

U.S. EXTENDS ITS LEADING EFFORT TO REMOVE WORLD'S LAND MINES

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 4, 1997

Mr. BEREUTER. Mr. Speaker, this Member commends to his colleagues the editorial which appeared in the Omaha World-Herald on November 4, 1997.

U.S. EXTENDS ITS LEADING EFFORT TO REMOVE WORLD'S LAND MINES

The U.S. government has made a considerable effort to prevent people around the world from being killed or injured by antipersonnel mines. To the credit of the Clinton administration, the United States is about to do more.

President Clinton has announced a U.S.-led campaign to rid the world of the devices in the next dozen years. Secretary of State Madeleine Albright said the United States will contribute $80 million this year to an international effort to clean up minefields, double the U.S. contribution the previous year.

Some people might think a contradiction exists. The U.S. government is the major holdout from a proposed treaty banning mines. Clinton has said that the United States won't sign unless the treaty is amended to allow continued use of the devices along the U.S.-guarded demilitarized zone separating North and South Korea. A committee that won the Nobel Peace Prize for pushing for a global anti-mine treaty has treated the Clinton policy—and the president himself—with scorn and contempt.

The biggest problem with land mines has its roots in the past, however, not in the future behavior of the United States. An estimated 100 million of the explosive devices remain in the ground in more than 60 countries, from Bosnia to Angola and from El Salvador to Cambodia. Many of the mines were planted in haste by guerrilla forces—people who neither sign global treaties nor leave any record of where they lay their mines.

About 26,000 people are killed or injured by the devices every year, many of them children at play. This is the problem that the plan announced by Clinton and Ms. Albright is designed to solve by 2010.

American forces have already drastically curtailed their use of land mines. Part of the reason is that U.S. mines caused many U.S. casualties. The mines still in use are mostly manufactured to lose their explosive force after a few weeks. The locations are carefully recorded. The mines are removed when no longer needed.

As to U.S. reservations about the treaty: The situation on the Korean peninsula has few parallels anywhere in the world. A superpower that has been entrusted by peace-loving nations—and is expected by them—to prevent war in Korea is hardly going to add to the unmapped minefields that are causing the 26,000 casualties a year. The United States isn't out of line with its request to continue using land mines in Korea if it signs the treaty.

Indeed, treaties don't bind guerrilla forces. They are often ignored by aggressors. A land mine treaty, even if signed by the United States, would guarantee little in the long run.

On the other hand, an international clean-up of minefields could do a lot to reduce mine-related casualties. The campaign to find mined areas and remove the explosives safely is a noble humanitarian effort. U.S. participation is well worthwhile.

ACCOMPLISHMENT OF THE HEALTH CENTER PROGRAMS

SPEECH OF

HON. LOUIS STOKES

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 29, 1997

Mr. STOKES. Mr. Speaker, I want to thank my colleague, the gentleman from, Illinois, Congressman DANNY K. DAVIS, for sponsoring this special order this evening. I am very pleased to join him in this discussion on an issue of great importance to the Congress and this Nation—community health centers.

The recently enacted Balanced Budget Act of 1997 will make nearly $13 billion in Medicaid cuts from fiscal year 1998 through fiscal year 2002. This will severely impact the way in which health care is financed and delivered across the Nation. The numbers of uninsured Americans and the cost of health care services are continuing to rise. Yet, the availability of financial resources to address these concerns is diminishing. Thus, we must carefully consider community health centers as a model of community-directed health care for our changing health care system.

Community health centers are unique public/private partnerships which were created to provide increased access to health care services for the Nation's poor and underserved. Located in isolated rural and inner city areas, with few or no physicians, that suffer with high levels of poverty, infant mortality, elderly and poor health, they hold the distinction of being locally-owned and operated by the very communities that they serve.

Our health care system relies heavily on charitable care to meet the growing health needs of the Nation's 37 million uninsured—as well as the million individuals with insufficient coverage. Community health centers provide invaluable health care services to more than 10 million of the Nation's most vulnerable and underserved individuals. These patients include minorities, women of childbearing age, infants, persons infected with HIV, substance abusers and/or the homeless and their families. In fact, according to the Bureau of Primary Health Care, of the 33 million patient encounters at community health centers in 1996, 65 percent of the persons served were African-American and other minorities, 85 percent were poor, and 41 percent were uninsured.

Community health centers are the true safety-net providers of this Nation. As such, they obligated to provide health care services to all patients without regard to their ability to pay. Patients are billed for health services on a sliding fee scale in order to ensure that neither income nor lack of insurance serves as a barrier to care. And, Federal grants received by the centers are used to subsidize the cost of health care that is provided to uninsured patients as well as those services which are not covered by Medicare, Medicaid, or private insurance.

Community health care centers also provide high quality cost-effective care. In fact, studies show that the average total health care costs to patients are 40 percent lower than for other providers that serve the same population. Significant savings are also achieved by reducing the need for hospital admissions and emergency care.

Mr. Speaker, as a member of the House Appropriations Subcommittee on Labor, Health and Human Services, and Education, as a health advocate, and as chairman of the Congressional Black Caucus Health Braintrust, I am concerned about the toll that the changing health care market is taking on many families across this Nation. Congress must recognize that community health centers play a critical role in filling health care service gaps. Therefore, I join my colleague, Congressman DAVIS, in urging our colleagues to ensure that this unique provider of health care services is preserved and strengthened to accommodate the growing health needs of the most vulnerable among us, the poor and the underserved.

CBO ANALYSIS OF KYL-ARCHER AMENDMENT: BAD NEWS FOR SENIORS AND DISABLED

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 4, 1997

Mr. STARK. Mr. Speaker, last week, the Congressional Budget Office made public its analysis of the budget impact of the Kyl-Archer amendment which will make it much easier for doctors to charge Medicare beneficiaries anything they want, anytime they want.

The Kyl-Archer amendment effectively ends Medicare insurance. There is no insurance if you never know whether the doctor is going to reject your Medicare card and ask you to pay the whole bill out of your pocket.

CBO describes a scary Halloween trick for the Nation's seniors and disabled. Doctors will be able to hold sick patients hostage for higher payments, fraud will increase, total national health care spending—already by far the highest in the world—will increase. It will be a treat for doctors, but the end of insurance peace of mind for seniors.

The full CBO letter analysis follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 30, 1997.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: At your request, the Congressional Budget Office (CBO) has reviewed H.R. 2497, the Medicare Beneficiary Freedom to Contract Act of 1997, as introduced on September 18, 1997. (S. 1194, an identical bill, was introduced in the Senate on the same day.)

Direct contracting allows beneficiaries to make financial arrangements with health providers outside of the established Medicare payment rules. The direct contracting provision in current Medicare law, enacted in the Balanced Budget Act of 1997 (P.L. 105–33), requires providers contracting directly with patients to forgo any Medicare reimbursement for two years. Under that condition, CBO expects that direct contracting will almost never be used.

H.R. 2497 would eliminate the two-year exclusion period, allowing health providers to contract directly with their Medicare patients on a claim-by-claim basis. For example, a physician could bill Medicare for an office visit while directly contracting with the patient for an associated test or procedure.

Enactment of H.R. 2497 would affect Medicare outlays. Because of uncertainties about the number of claims that would be separately contracted and about the effectiveness of the regulatory oversight of those contracts by the Health Care Financing Administration (HCFA), however, CBO cannot estimate either the magnitude or the direction of the change in Medicare outlays that would ensue.

With Medicare's restrictions on balance billing—which limit the amount beneficiaries must pay for services covered by Medicare—providers may in some cases receive lower payments than what their patients would have been willing to pay out of pocket. The bill would allow physicians and other health care providers to increase their incomes by negotiating direct contracts that included prices in excess of Medicare's fees, effectively bypassing the limits on balance billing. For some services, CBO believes that such contracting would not be very widespread because few beneficiaries would be willing to pay the entire fee (not just the difference between the provider's charge and what Medicare would have paid). For other services—such as those where the need for timely medical treatment might increase patients' willingness to pay—direct contracting could become much more common.

If direct contracting continued to be rarely used, there would be no changes in benefit payments, no additional difficulties in combating fraud and abuse, and no major new administrative burdens placed on HCFA.

If direct contracting were extensively used, however, Medicare claims could be significantly reduced. At the same time, HCFA's efforts to screen inappropriate or fraudulent claims could be significantly compromised because it would be difficult to evaluate episodes of care with gaps where services were directly contracted. Furthermore, HCFA would be unlikely to devote significant administrative resources to the regulation of direct contracting. HCFA's efforts to administer other areas of Medicare law, including many of the new payment systems envisioned in the Balanced Budget Act, will continue to strain the agency's resources. Without adequate regulatory oversight, unethical providers could bill Medicare while also collecting from directly-contracted patients.

Although the impact of H.R. 2497 on the federal budget is uncertain, the bill would almost certainly raise national health spending. Even if direct contracts were rarely used, payments made under those contracts would probably be higher than what Medicare would have paid, and Medicare's efforts to combat fraud and abuse would probably be hampered to some extent.

If you have any questions about this analysis, we will be pleased to answer them. The CBO staff contact is Jeff Lemieux.

Sincerely,

JUNE E. O'NEILL,
Director.

CAMPAIGN FINANCE REFORM

HON. RON KIND

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 4, 1997

Mr. KIND. Mr. Speaker, we are starting another week of legislative session, possibly the last week this year, and still no campaign finance reform. The news over the weekend was encouraging for supporters of reform. Speaker GINGRICH announced that the House will schedule debate on campaign finance reform no later than March 6 next year.

This is another positive step on the road to reform, but it is not the answer. As I and many of my colleagues have warned, a vote next year, during an election year, is not satisfactory. By March of next year we will all be involved in our reelection campaigns, and any change will be too late to take effect in the 1998 elections. Mr. Speaker, rather than wait until March of next year to consider this issue, the House should take up campaign finance reform this week. There are a wide variety of bills currently introduced that could be considered. The House Committee on Government Reform and Oversight has been holding hearings on these bills. We have the time to consider campaign reform legislation this week and have a bill passed before we adjourn for the year.

The voters of this Nation want us to clean up our house. The leadership in the Senate and the House have agreed to allow a vote on this issue. The time to act is now. I refuse to take ''no'' for an answer.